

Young Scholars Series

The Problems with Linking Specific Foreign Policy to Abortion in Developing Countries:

Critical review of Eran Bendavid, Patrick Avila & Grant Miller,
“United States aid policy and induced abortion in sub-Saharan
Africa,” in *World Health Organization Bulletin Online*, 2011

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Lucia Muchova¹

Can a U.S. policy that withholds funds for abortion (the Mexico City Policy) lead to more abortions in developing countries? A recently published paper in the World Health Organization Bulletin by Bendavid, Avila and Miller says that it may, but there are fundamental problems with the study. The study is based on analysis of 20 sub-Saharan African countries, and suggests that countries more exposed to the Mexico City Policy experience a higher rate of induced abortions than the less exposed countries when the policy is in place. Such a finding, if correct, can have important implications for development policy. However, the study’s reliance on incomplete data significantly weakens the conclusions drawn by the authors. The importance of the issue warrants further scrutiny.

Background

The United States announced the “Mexico City Policy” in 1984 at the International Conference on Population in Mexico City. The policy requires all non-governmental organizations (NGOs) active abroad that receive funding for population programs from the United States to refrain from performing or actively promoting abortion as a method of family planning. The Mexico City Policy was rescinded by President Clinton in 1993 and reinstated by President Bush in January 2001. Following the directive from President Bush to reinstate all the requirements of the Policy, the U.S. Agency for International

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Development (USAID) issued guidelines for its implementation in development projects. Certain large NGOs involved in population programs, such as the International Planned Parenthood Federation (IPPF), rejected the terms of the Policy, but the majority of NGOs active in family planning accepted the conditions and qualified for U.S. funding.²

For their study, Bendavid, Avila and Miller identified the Mexico City Policy as “the policy requiring all non-governmental organizations operating abroad to refrain from performing, advising on, or endorsing abortion as a method of family planning if they wish to receive federal funding.”³ The article, however, fails to mention several important specifications of the policy’s implementation. As the Congressional Research Service (CRS) report to Congress from April 2, 2001 makes clear, the Mexico City Policy uses a particular definition of abortion that also includes important exceptions to the no-abortion rule. Abortion is defined as a “*method of family planning* when it is for the purpose of spacing births, including (but not limited to) abortions performed for the physical or mental health of the mother.” “Promotion of abortion” includes activities like lobbying foreign governments to legalize abortion as a method of family planning, providing family planning counseling on the benefits and availability of abortion or encouraging women to consider abortion.⁴

Crucially, however, the Mexico City Policy contains the following exceptions: (1) abortions may be performed if the life of the mother would be endangered if the fetus were carried to term; (2) abortions may be performed following rape or incest; (3) health care facilities may treat injuries or illnesses caused by legal or illegal abortions (post-abortion care).⁵

Looking at the UN World Abortion Policies 2007 and 2011 charts, we find that while all twenty countries analyzed in the paper allow abortion in cases where the mother’s life is threatened, only seven out of twenty countries allow abortion following incest or rape.⁶ Only one country (Zambia) has legalized abortion for economic or social reasons, and none of the countries allow abortion on request.⁷ Rather than imposing restrictions on African countries, the Mexico City Policy, when it was in place, was in fact in line with the countries’ existing legal system.

Review of the data used

Restating the conclusion of the study under examination, the data show that “the induced abortion rate in sub-Saharan Africa rose in high-exposure countries relative to low-exposure countries when the Mexico City Policy was re-introduced.”⁸ The accuracy of the model used to arrive at this conclusion depends on two things: (1) the precision of the data on induced abortions; and (2) the definition of “high-” and “low-exposure” countries. There are problems with both of these factors in the study.

² Congressional Research Service (CRS), *International Family Planning: The “Mexico City” Policy*, CRS Report for Congress, updated April 2, 2001. As of 2 November 2011, available at: http://www.policyalmanac.org/culture/archive/abortion_Mexico_City.pdf

³ Eran Bendavid, Patrick Avila and Grant Miller, “United States Aid Policy and Induced Abortion in sub-Saharan Africa,” *Bulletin of the World Health Organization* (published online), September 27, 2011, 2.

⁴ Ibid. (Emphasis added.)

⁵ Ibid.

⁶ United Nations, *UN World abortion policies chart 2011*, as of 2 November 2011 available at: <http://www.un.org/esa/population/publications/2011abortion/2011wallchart.pdf>

⁷ Ibid.

⁸ Bendavid et al., 1.

Problems with estimating induced abortions

To estimate data on induced abortions, the authors used “longitudinal, individual data on terminated pregnancies collected by Demographic and Health Surveys (DHS).”⁹ The DHS statistics do not provide exact data on abortion, and do not directly distinguish between induced abortions and unintended pregnancy termination, also known as miscarriage.¹⁰ As a consequence, DHS calendar data is used to develop an algorithm that to distinguish between induced and spontaneous pregnancy terminations.¹¹ This algorithm is used in Bendavid, Avila and Miller’s paper. In contrast to the WHO methodology of estimating induced abortion rates, the DHS calendar data does not use information available in medical records showing clinical evidence of induced abortion.¹² As a consequence, the DHS classification algorithm applied in Bendavid, Avila and Miller’s paper cannot classify any termination as “certainly induced.” Instead, the algorithm uses three categories: (1) probably spontaneous; (2) probably induced and (3) unclassifiable due to insufficient information.¹³ Table 1 summarizes the algorithm to classify pregnancy terminations.

Although the classification algorithm method has been seen as a fair estimate of induced abortion rates where no precise data is available, it still has some important shortcomings. Tulane University Medical Center Associate Professors Robert J. Magnani and H. Gilman McCann, together with Naomi Rutenberg, the Deputy Director of the Africa Family Planning Operations Research Project in The Population Council, Nairobi, who developed this algorithm, have also admitted some of its inadequacies. They conclude that the classification scheme performs reasonably well in identifying cases of induced abortions, but that it overestimates the number by generating a large number of “false positives,” or spontaneous terminations classified as induced.¹⁴ Essentially, the method tends to overestimate the number of induced abortions.¹⁵ If uncorrected for possible misreporting, there is a 35% probability of pregnancy terminations coming out as “false positives” in the algorithm. Assuming that 50% of “false positives” were due to reporting error, the probability of “false positives” is lowered, but still at about 20%.¹⁶ For women over 30, the probability of a “false positive” could be as high as 50% without accounting for potential misreporting.¹⁷ Even if we allow for the possibility of under-reporting of induced abortions for legal reasons or due to stigma, the inaccuracy of the method is notable.

⁹ Ibid., p. 3.

¹⁰ DHS, *Description of the Demographic and Health Surveys*, Individual Recode, Data File, DHS III. As of 2 November 2011 available at: <http://www.measuredhs.com/pubs/pdf/DHSG4/Recode3DHS.pdf>. See comments on V228–234.

¹¹ Robert J. Magnani, Naomi Rutenberg, H. Gilman McCann, “Detecting Induced Abortions from Reports of Pregnancy Terminations in DHS Calendar Data,” *Studies in Family Planning*, Vol. 27, No. 1 (Jan.–Feb., 1996). As of 2 November 2011 available at: <http://www.jstor.org/stable/2138076>. Accessed: 02/11/2011.

¹² Ibid., 38.

¹³ Ibid.

¹⁴ Ibid., 39.

¹⁵ Ibid., Table 3, 39.

¹⁶ Ibid., Table 6, 41.

¹⁷ Ibid.

Table 1: Decision algorithm for classifying reported terminations as either spontaneous or induced

CONDITION	CLASSIFICATION
Third-trimester termination	Probably spontaneous
Respondent discontinued contraceptive use in order to become pregnant	Probably spontaneous
Contraceptive use failure (A)	Probably induced
Unwanted pregnancy (B)	Probably induced
Respondent married or in union and of parity 0 or 1 at termination	Probably spontaneous
Respondent neither married nor in union and younger than 25	Probably induced

Source: based on Robert J. Magnani, Naomi Rutenberg, H. Gilman McCann, "Detecting Induced Abortions from Reports of Pregnancy Terminations in DHS Calendar Data", *Studies in Family Planning*, Vol. 27, No. 1 (Jan. - Feb., 1996), p.38.

(A) Defined as all pregnancies in which contraceptive use was reported to have been discontinued due to pregnancy, plus all pregnancies reported as occurring within two months of contraceptive discontinuation. A two-month "window" is used since the calendar protocol did not permit a contraceptive discontinuation and a pregnancy to be recorded in the same month. (B) Defined as a pregnancy occurring after a live birth that was reported as having been unwanted (with respect to number), or a pregnancy that would have resulted in the number of surviving children exceeding the desired number had it ended in a live birth.

Missing data

The study also suffers from a lack of verifiable data. To determine an increase or decrease in the odds ratio of having an induced abortion in the twenty countries of focus, the authors compared the data for the 2001–2008 period with data collected before the reinstatement of the Mexico City Policy (1994–2000). Looking at Table 1 provided in the Appendix of the Bendavid et al. paper, we can see that about 40% of the data on abortion for the 1994–2008 period is missing. The proportion of data missing for what the authors classify as high-exposure and low-exposure countries is approximately the same.

To some extent, lack of data poses less of an obstacle when it is standardized and aggregated. This was done in the paper, for example, by calculating abortion-rate per 10,000 woman-years (defined as a year in the reproductive life of a sexually active woman) for groups of countries classified as having low and high exposure, respectively. However, there is questionable accuracy in the comparison between abortion rates in 1994–2000 and 2001–2008 for countries where all or most of the data for the early period is unavailable (such as Nigeria, Swaziland, Zambia, Benin, Niger, Sierra Leone and Guinea). In the case of Zambia, the missing data creates a particular challenge, because Zambia was among the top three recipients of U.S. foreign aid for reproductive health throughout the studied period. Furthermore, this country consistently received the largest per capita U.S. aid in the period 2001–2008, and the U.S. provided a large percentage of overall Official Development Assistance (ODA) for reproductive health for Zambia throughout 1994–2008.¹⁸ A failure to compare abortion rates in different periods for this important country, in relation to U.S. aid presence in the reproductive health sector, is just one important illustration of a wider problem of insufficient data in the study.

¹⁸ OECD, ODA reported data for US ODA for reproductive health 1995-2008. As of 19 October 2011 available at: <http://stats.oecd.org/Index.aspx?DatasetCode=CRSNEW>

Weaknesses of the exposure index

Though the authors do not explicitly claim to establish a direct causal relationship between the Mexico City Policy and abortion, their efforts to isolate the effects of the Policy from other intervening variables imply that they seek to find evidence that would suggest such a relationship exists.

The authors' claim to be able to isolate the effects of the Mexico City Policy relies on their ability to construct what they call an "exposure index". According to the authors, this enabled them to control for confounding factors such as fixed effects related to the country and the year of reporting, women's place of residence, their level of education, use of modern contraceptives and funding for family planning activities coming from donors other than the U.S.¹⁹ Controlling for intervening variables is crucial in establishing a causal relationship. However, the exposure index cannot quite fulfill this role.

The level of exposure was qualified by using the mean value of U.S. financial assistance per capita for family planning and reproductive health in the period of 1995–2000.²⁰ A dichotomous variable was created: based on the level of U.S. assistance in 1995–2000, the countries were divided into two groups: high-exposure countries, which received more than the median level, and low-exposure countries, which received less than the median level of assistance in the same period. The assumption at work when designing this indicator was that women in countries with high exposure in 1995–2000 were more affected by the reintroduction of Mexico City Policy in 2001.

Gaps in the data

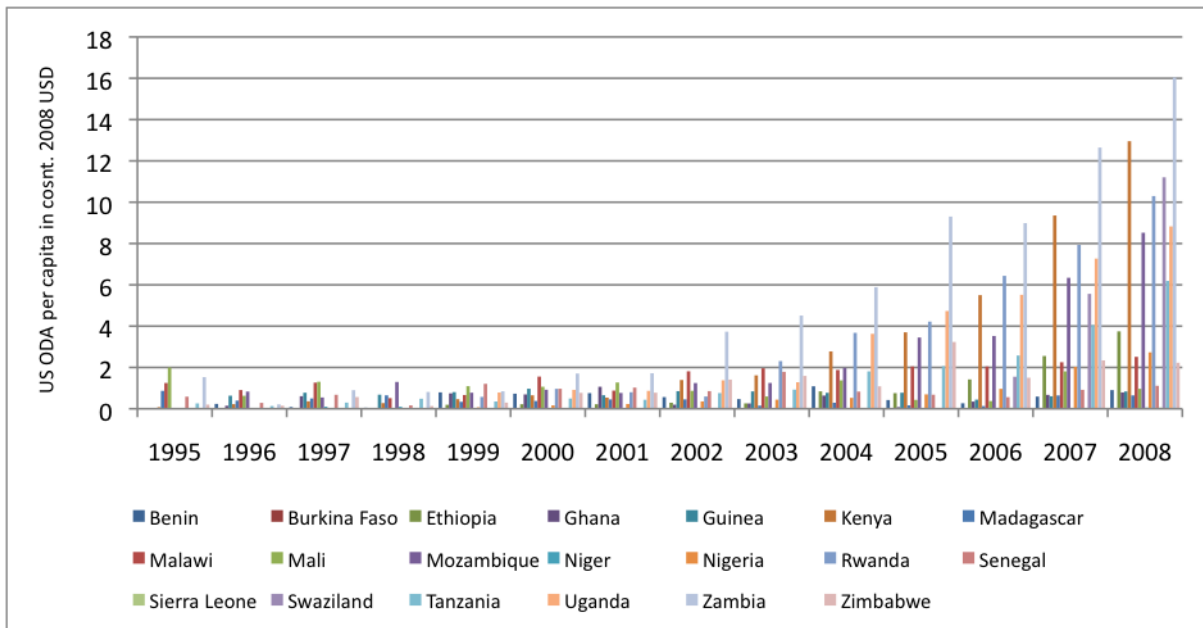
The exposure index provides the fundamental tool to connect U.S. aid policy to abortion. However, it contains serious imperfections. Firstly, the data for US ODA disbursed for population programs and reproductive health, obtained from the Creditor Reporting System of the Organisation for Economic Co-operation and Development (OECD) and used as the primary source for the exposure index, contains significant gaps for the period 1995–2000. For some countries, such as Sierra Leone, Burkina Faso and Swaziland, no data on U.S. aid is available for the given period; for others, the majority of data is missing for 1995–2000 (particularly for Ethiopia, Rwanda and Uganda,). Significantly, for low-exposure countries, only 40% of data on ODA for population programs and reproductive health services is available for the period 1995–2000. The classification of countries is, therefore, based on a median level of US ODA that excludes three countries and includes highly porous data for another three.

If there were clear trends in the development of US ODA for reproductive health services in these particular countries, the missing data would pose a smaller challenge. However, foreign aid flows into particular countries tend to be volatile, and aid for reproductive health is no exception, as demonstrated in Figure 1. Given the volatile nature of foreign aid, it is difficult, if not impossible, to accurately estimate any missing data. As a consequence, the mean level of assistance will fail to capture the real levels of assistance in particular years between 1995 and 2000. The larger the gaps in the data available, the more unreliable the median will be, leading to greater arbitrariness in the exposure index. In the case of those countries for which no data is available for 1995–2000 period, it is questionable on what basis they were classified as high- or low- exposure in the first place.

¹⁹ Eran Bendavid, Patrick Avila and Grant Miller, "United States Aid Policy and Induced Abortion in sub-Saharan Africa", Bulletin of the World Health Organization (published online), September 27, 2011, p.2.

²⁰ Bendavid et al., 4.

Figure 1: US ODA for Population programs and reproductive health 1995-2008



Source: based on: OECD, ODA reported data for US ODA for reproductive health 1995-2008, converted to const. 2008 USD using CPI inflation index from Bureau of Labor Statistics (http://www.bls.gov/data/inflation_calculator.htm); Population data to calculate per capita ODA were taken from *World Bank Databank*, Total Population data 1995-2008.

Complex development of aid flows

Secondly, due to the same lack of available data on US ODA in the earlier period, it is difficult to determine to what extent the reinstatement of the Mexico City Policy affected aid disbursement to the twenty African countries. As the OECD statistics show, per capita US ODA for population programs and reproductive health has been rising overall, with large increases in Kenya, Rwanda, Zambia and Zimbabwe (see Figure 1) over the period 1995–2008. Similarly, the overall world ODA for reproductive health and family planning was on the rise during the examined period. The proportion of U.S. funding to total international funding fluctuated throughout the entire period, but the overall funding maintained a rising tendency.

In numerical terms, only three countries (Madagascar, Mali and Niger) received a higher average per capita US ODA for reproductive health from 1995–2000 than after 2001. Three countries could not be compared due to lack of data (Burkina Faso, Swaziland and Sierra Leone) and fourteen countries experienced an increase in U.S. per capita funding in the period 2001–2008. Six out of nine countries that experienced more than 50% increase in average per capita aid from 1995–2000 to 2001–2008 period were among the low-exposure countries. Table 2 summarizes the changes in average per capita US ODA for reproductive services before and after 2001. Year-by-year changes are illustrated in Figure 2. According to Bendavid, Avila, and Miller, the fact that women in low-exposure countries have a smaller chance of having an induced abortion compared to those in the high-exposure group could potentially be linked to the fact that low-exposure countries saw a significant average increase in per capita aid. The increase in U.S. per capita funding for both high-exposure and low-exposure countries indicates that the Mexico City Policy did not reduce overall funding for family planning. The opposite seems to be true: the period of 2001–2008 saw an overall increase in both U.S. per capita aid and overall international aid provided

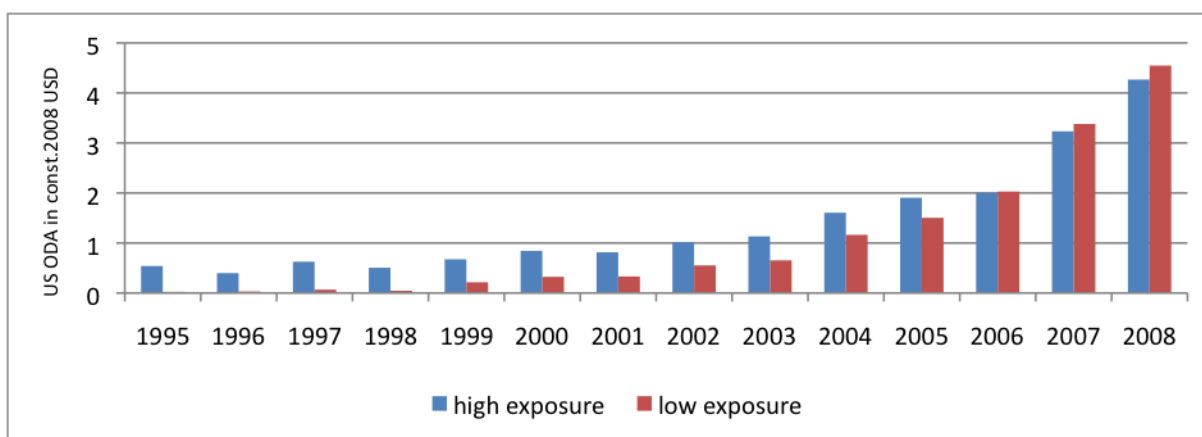
for population programs and family planning, as compared to 1995–2000. In fact, the one factor that the paper does not seem to control for is the increase in U.S.-provided aid for reproductive health over time.

Table 2: Changes in average per capita US ODA 1995-2008

	Exposure	Average ODA 2001-2008	Average ODA 2001-2008	Change 1995-2008
Benin	High	0.3783	0.6325	40%
Burkina Faso	Low	NA	0.0367	NA
Ethiopia	Low	0.2057	1.2612	84%
Ghana	High	0.4440	0.5056	12%
Guinea	High	0.7731	0.7223	-7%
Kenya	Low	0.3414	4.7300	93%
Madagascar	High	0.5206	0.3671	-42%
Malawi	High	1.0263	1.9242	47%
Mali	High	1.2180	0.9614	-27%
Mozambique	High	0.8750	3.3852	74%
Niger	Low	0.0995	0.0363	-174%
Nigeria	Low	0.0539	0.9968	95%
Rwanda	Low	0.7698	4.5328	83%
Senegal	High	0.6475	0.9709	33%
Sierra Leone	Low	NA	0.0398	NA
Swaziland	Low	NA	4.5854	NA
Tanzania	High	0.3371	2.3509	86%
Uganda	Low	0.8501	4.1877	80%
Zambia	High	1.0013	7.8541	87%
Zimbabwe	Low	0.3518	1.7709	80%

Source: based on: OECD, ODA reported data for US ODA for reproductive health 1995-2008, converted to const. 2008 USD using CPI inflation index from Bureau of Labor Statistics (http://www.bls.gov/data/inflation_calculator.htm); Population data to calculate per capita ODA were taken from World Bank Databank, Total Population data 1995-2008.

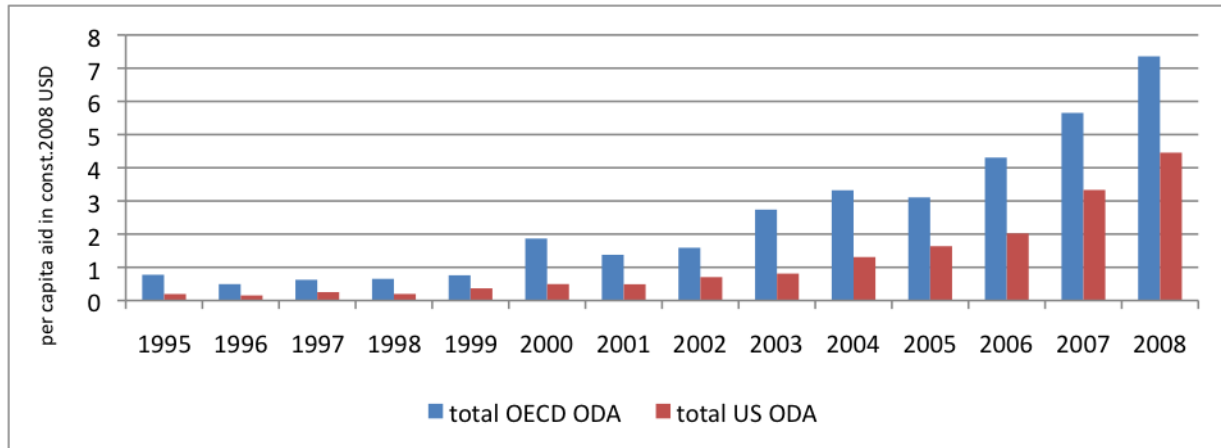
Figure 2: US ODA per capita in high and low exposure countries



Source: based on: OECD, ODA reported data for US ODA for reproductive health 1995-2008, converted to const. 2008 USD using CPI inflation index from Bureau of Labor Statistics (http://www.bls.gov/data/inflation_calculator.htm); Population data to calculate per capita ODA were taken from *World Bank Databank*, Total Population data 1995-2008. [per capita ODA calculated based on total ODA per group (low/ high exposure) per year divided by total population per group per year]

Available OECD data suggests that U.S. aid provisions to particular developing countries fluctuated in a similar way with other donors' provisions from year to year. Higher U.S. assistance was usually associated with higher assistance by the remaining donors over the whole period 1995–2008, as shown in Figure 3. The development of aid flows is a result of manifold causes, and manifests itself differently country by country. To try to control for all the different causes of the fluctuating aid in the twenty African countries in order to focus on one particular foreign policy issue is overly ambitious; indeed, it is virtually impossible.

Figure 3: US and World ODA for Population programs and reproductive health for twenty African countries 1995-2008



Source: based on: OECD, ODA reported data for US ODA for reproductive health 1995-2008, converted to const. 2008 USD using CPI inflation index from Bureau of Labor Statistics (http://www.bls.gov/data/inflation_calculator.htm); Population data to calculate per capita ODA were taken from *World Bank Databank*, Total Population data 1995-2008.

Problematic interpretation of data

Thirdly, even if we assume that the classification of countries as high-exposure and low-exposure is correct, there are still problems with the study's interpretation of data. The second figure in Bendavid, Avila and Miller's paper shows that the rate of induced abortions increased greatly in the period of 2001–2008 for the high-exposure countries, whereas the abortions rate seems to have declined or stabilized in the same period for low-exposure countries. Apart from Zambia, the other top five recipients of U.S. aid for reproductive health (Uganda, Swaziland, Rwanda and Kenya) averaged over 2001–2008 period are all low-exposure countries, and hence belong to the group with lower rate of induced abortions. We could argue, as the paper seems to suggest, that after the 2001 reinstatement of the Mexico City Policy, resources were allocated away from the high exposure countries, and consequently these countries lacked sufficient access to modern contraception, leading to increased rate of abortions as an alternative form of family planning.²¹ We could also say, however, that the 2001–2008 increase in U.S. per capita funding for anti-abortion reproductive health policies, particularly in low-exposure countries relative to high-exposure countries, was associated with a lower rate of abortions. In other words, increased spending on reproductive health services in a manner consistent with the Mexico City Policy might have actually helped to prevent an increase in the rate of induced abortions.

²¹ Bendavid et al., 8.

On the whole, given the increase of U.S. per capita funding for nearly all countries in 2001–2008 as compared to 1995–2000, it is not warranted to argue, as the paper does, that the Mexico City Policy played a role in reducing per capita funding for reproductive health and family planning. What can be argued, though, is that funding was reallocated away from agencies that refused to sign up to the Mexico City Policy conditions (such as the abortion providers IPPF and Marie Stopes International) to those organizations that accepted the Policy. With no overall decrease in funding, it is difficult to persuasively argue that the Mexico City Policy led to “closing of clinics and women losing access to birth control pills and other modern contraceptives.”²² Even if some clinics were closed, we can still ask where the additional funding went if not to more family planning initiatives—very likely, towards more contraception.

To reach the conclusion that “reduced financial support for family planning may have led women to substitute abortion for contraception,” the authors briefly look at contraceptive use in the two groups of countries before and after the Mexico City Policy was reinstated.²³ They document a slower growth of contraception prevalence in the high-exposure countries relative to the low-exposure countries, and use this to support the argument that reducing the supply of birth control could lead women to use abortion as a form of birth control, thus leading to an increase in abortions.²⁴

To argue whether the relatively slower rise of contraception use in the high-exposure countries was linked with exposure to the Mexico City Policy, further research would be needed: looking at particular organizations financed by US ODA resources, and whether and how their operations changed after 2001. It might also be worth examining the significance of the fact that high-exposure countries’ increasing rates of contraceptive use began from a much lower level than those of the low-exposure countries. Starting from this unequal rate of contraceptive use in the first place, by 2008 the high-exposure countries had reached approximately the starting level of the low-exposure countries. Can we say that initial levels of contraception lead to a more rapid increase over time? What are the intervening factors influencing the differential growth of contraceptive use? These are questions that would require further research and are not answered by the paper at hand.

Implications and recommendations

Policymakers have good reason to be cautious about this study’s conclusions. The finding that the Mexico City Policy is associated with a higher rate of induced abortions in countries that were heavily exposed to this Policy has the potential to influence future foreign policy in favor of funding organizations that promote and provide abortion services in developing countries. However, due to noticeable weaknesses stemming from the underlying data and from the questionable classification of countries into high-exposure and low-exposure, the conclusions of the paper fall short. Moreover, the paper relies on abortion data that is unable to accurately isolate the true causes of pregnancy termination.

Instead of supporting policies to increase funding for abortion-performing and -promoting institutions, more UN and government funding should be aimed at collecting reliable data. It cannot be emphasized enough how harmful policymaking on the basis of inadequate data can be for the life and health of

²² Adam Gorlick, “Abortions in Africa increase despite Republican policy to curb payment for procedures,” *Stanford University News*, 28 September 2011. As of 2 November 2011 available at: <http://news.stanford.edu/news/2011/september/abortion-africa-policy-092811.html>

²³ Bendavid et al., Figure 3, p.20.

²⁴ Gorlick.

mothers and children. The damaging nature of abortion, whether legal or not, has been widely documented.

Funding organizations that perform or promote abortion as a method of family planning not only encourage the violation of domestic laws in many developing countries, but also undermine the very efforts to improve maternal health and the welfare of families. Instead, these funds would best be directed to programs that have demonstrated success in reducing maternal mortality, such as better overall health systems, provision of skilled attendants at birth and emergency obstetric care, as well as improving living conditions of families and raising access to education, particularly for young girls.

Given the lack of data for U.S. aid during the Clinton era (1993–2001), a more reliable study on the effects of the Mexico City Policy would include looking at the current Obama administration and comparing the rates of induced abortion for the periods 2001–2008 with those after 2008. By 2012, the Policy would have been rescinded for four years, providing a long enough period for a more robust study of its potential effects. One of Hill’s criteria for causality, dose–response relationship, states that increasing amount of exposure to certain factors increases the risk of developing a disease.²⁵ In our case, if the Mexico City Policy leads to increased rates of induced abortion, the withdrawal of the Policy (under the Obama administration) should, *ceteris paribus*, lead to decreased abortion rates. Given that *ceteris paribus* conditions can hardly be achieved in this context, however, obtaining a proof of causality would remain almost as difficult as for the authors of the paper under review.

Keeping in place the same categorization of countries into high- and low- exposure, it would, nonetheless, be interesting to observe the movement of induced abortion rates following the abandonment of the Mexico City Policy in 2008. If the trends observed in the period 2001–2008 continue, it will be much more difficult to attribute the higher probabilities of induced abortion to the exposure to Mexico City Policy. As such, other explanations would have to be sought to account for increased abortion rates.

Conclusion

The WHO-published study on the link between abortion rates and the US Mexico City Policy suffers from an imperfect methodology, missing data and subjective classifications. If any policy implications are to be drawn from the study, it is crucial to remember that the paper does not demonstrate an increase in the induced abortions rate in the high-exposure countries as a result of the Mexico City Policy. Rather, it may—if we accept its assumptions—show a correlation between higher rates of induced abortions in the high-exposure countries during the period when the Mexico City Policy was in place.

The Mexico City Policy, more often than not, can be seen as safeguarding developing countries from extensive pressure by NGOs to legalize abortion on demand.²⁶ If some organizations involved in

²⁵ A.B. Hill. “The Environment and Disease: Association or Causation?” *Proceedings of the Royal Society of Medicine*. May 1965; 58:295–300.

²⁶ Most countries in this study have legalized abortion only to a limited extent, which is consistent with the Mexico City Policy. Kathy Cleaver, the Director of Planning and Information for the Secretariat for Pro–Life Activities at the US Conference of Catholic Bishops, stated before the Committee on Foreign Relations of the US Senate in July 2001: “[...] far from forcing a policy on poor nations, the Mexico City Policy ensures that NGOs will not themselves force their abortion ideology on countries without permissive abortion laws as U.S. grantees. [The] vast majority of these countries have legal policies against abortion, and virtually all forbid the use of abortion as merely another method of birth control.” Statement at *Mexico City Policy: Effects of restrictions on international family planning finding* hearing before the Committee on Foreign Relations, U.S. Senate 117th Congress, first session, July 19, 2001.

family planning and reproductive health refuse to abide by these conditions, we are right to ask whether these are truly organizations that the US taxpayers ought to support and host nations invite into their countries.



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